

Registration District No. 10-136
FILED FEB 10 1944
28

Primary Registration District No. 200D

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 day
(Specify whether)

In this community 1 years, months or days

3. (a) PRINT FULL NAME WILLIAM A GANN

3. (b) If veteran, name war unk.

3. (c) Social Security No. unk.

4. Sex Male 5. Color or face White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Luella Gann 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased May - 15 - 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69 8 9 hr. min.

9. Birthplace Dallas Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER

12. Name John Gann

13. Birthplace unk. Tenn
(City, town, or county) (State or foreign country)

14. Maiden name unk. Kentucky

15. Birthplace unk. Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Oval Gann

(b) Address Lockwood Mo

17. (a) Burial (b) Date thereof Jan 24 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Conway Mo

18. (a) Signature of funeral director [Signature]

(b) Address Buffalo Mo

19. (a) 1-24-44 (b) [Signature]
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 30

(c) City or town Buffalo Mo
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1944 hour 12 minute 50 P. M.

21. I hereby certify that I attended the deceased from Jan 23
1944, to Jan 24 1944.

that I last saw her alive on Jan 24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

Valvular Heart Disease Duration 9 mo

Due to Hemoplegia from emboli 18 hrs

Other conditions (Include pregnancy within 3 months of death)

92d

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(a) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]

Address Springfield Mo Date signed 1/24/44

984

FEB 16 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Leonard B Jones

Licensed Embalmer No.

7508

P. O. Address

Buffalo, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.